Surgical Center at Millburn

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of the Notice of Privacy Policies for the groups listed above, detailing how my Protected Health Information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction (s) concerning the use of my personal medical information:

_____

_____

_____

Signed:_____ Date: _____

If not signed by patient, indicate relationship to patient (e.g. spouse, guardian)

Relationship: _____ Witnessed by: _____

Authorization to Release Medical Records

I, _____, authorize the Surgical Center at Millburn to release my medical information to:

_____

_____

_____

Internal use only:

If patient or patient's representative refuses to sign acknowledgement of receipt of Notice, please document the date and time the Notice was presented and sign below.

Presented on (date and time): _____

By: (name and title): _____

State reason for refusal to sign:

_____

_____